STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165286	A. BUILDING _____ B. WING _____	C 11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE HILL CARE CENTER	909 6TH STREET TRAER, IA 50675

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiency relates to the investigation of facility reported incident #70347 & #71575 and complaint #72081. However the deficiency was corrected prior to surveyor entrance on October 16, 2017 so is past non-compliance. (See code of federal regulations (42CFR) Part 483, Subpart B-C) Facility reported incident #67971 was not substantiated.	F 000		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility staff failed to provide adequate supervision and a safe transfer for 1 of 6 residents reviewed (Resident #1). Resident #1 sustained an injury to his head when staff failed to secure him in the whirlpool tub during a bath. The facility reported a census of 72 residents. Findings include: 1. According to Resident #1's Minimum Data Set (MDS) dated 8/10/17 the resident had diagnoses which included Peripheral Arterial Disease, Alzheimer's Disease, cardiac arrhythmia's and idiopathic scoliosis. The resident had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive ability. Resident #1 required extensive assistance of 2 staff for bed mobility, transfers, toilet use and personal hygiene and required physical help with bathing. The resident could stabilize with staff assistance only when standing or transferring between bed and chair. Review of the Care Plan updated on 8/17/17 Resident #1 utilized an EZ Stand as needed for transfers and has a history of leaning forward in the wheelchair. The care plan informed the staff the resident experiences chronic back pain due to scoliosis and back weakness. The care plan directed staff to provide physical assistance with bathing. Review of the Fall Risk Evaluation dated 8/17/17 Resident #1 had a fall risk score of 16, which	F 323	Past noncompliance: no plan of correction required.	

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F 323	Continued From page 2 indicated a high risk for falls. Review of a Fall/Incident Report dated 10/11/17 at 8:40 p.m. Resident #1 had a fall from a raised whirlpool chair after a bath. The resident fell from the whirlpool chair and landed face down on the floor with his head wedged under the open door of the whirlpool. The staff who assisted the resident with the bath indicated she did have the safety belt on but it wasn't tight around the resident's trunk. The staff summoned the local ambulance who transferred the resident to a local hospital for an evaluation and treatment. According to the Progress Notes dated 10/11/17 at 8:40 p.m. Staff A CNA called Staff B LPN into the whirlpool room. Staff A explained to Staff B when she transferred Resident #1 out of the whirlpool, the resident held one hand on the side of the whirlpool and one hand on the whirlpool door. As the staff pulled the resident back the resident fell forward hitting his head on the side of the whirlpool and then fell onto the floor. Staff A indicated the resident sustained a large laceration to the left forehead and had discomfort with movement. Staff B summoned the local ambulance for transport to the hospital. Review of a Progress Note dated 10/12/17 at 2:30 a.m. the facility received an update from the local hospital, Resident #1 required 29 sutures to the head and his heart rate in the 30's. Resident #1 admitted to the local hospital for bradycardia. Review of a Progress Note dated 10/14/17 at 6:00 p.m., revealed Resident #1 returned to the facility via ambulance. During an interview with Staff A on 11/21/17 at	F 323		

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F 323	Continued From page 3 2:00 p.m., Staff A stated she gave Resident #1 a whirlpool bath on the evening of 10/11/17. Resident #1 required assistance of 2 staff to sit in the whirlpool chair, he was transferred to the whirlpool room and bath completed. Staff A stated when she and another staff member placed him in the chair she applied the safety belt but it wasn't tight. Staff A stated she could put 2 hands between the belt and the resident's abdomen, indicating she kept the belt loose because it's the way the resident liked it. After she completed the bath, Staff A lifted the mechanical chair up into the air, approximately 28 inches, just enough to clear the resident's feet from the bottom of the whirlpool door. Staff A stated when she lifted the resident up and moved him out of the tub, the resident leaned forward and grabbed the door of the whirlpool and the edge of the tub. Resident #1 fell forward out of the whirlpool chair, struck his face on the tub and landed face down on the floor. The resident struck his head on the floor. Staff A stated she initially thought the chair strap broke but she admitted she had the strap on incorrectly and the belt became unfastened, causing the resident to fall. During an interview with Staff B on 11/21/17 at 1:35 p.m. Staff B stated staff called her to the whirlpool room. Staff B stated she witnessed Resident #1 laying on the floor of the shower room, next to the whirlpool tub with his head wedged under the open whirlpool door. The resident found to be bleeding from the head. The staff called 911, upon arrival to the facility, EMS staff removed his head from under the whirlpool tub and transported the resident to a local hospital. Staff A initially told Staff B the whirlpool belt broke and the resident fell from the whirlpool chair. Staff B stated Resident #1 had a history of	F 323		

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F 323	Continued From page 4 leaning forward in his wheelchair. A review of the Tub Bath Whirlpool Bathing System (Sitting Tub) instructed staff to follow the precautions to maintain the safety of residents. The instructions (#15) directed staff to position the resident in the tub chair designed for the system and ensure the resident is safety secure in the chair. During an interview with Director of Nurses (DON) on 11/21/17 at 10:05 a.m., the DON stated during her investigation it was determined the whirlpool seat belt was not on as tight as it should have been and it was applied incorrectly. The DON stated the facility did re-education with staff on the proper application of the whirlpool seat belt after the resident fall. The facility completed the following: On 10/13/17 the facility identified the root cause as staff failed to secure the buckles, and resident had not been fastened correctly causing the resident to fall and sustain an injury. On 10/13/17 the facility started educating staff (nurses and CNAs) and completed this on 10/16/17 with demonstration of the seat belt placement and securing residents in the whirlpool bath. On 10/13/17, staff would check random belts during showers. The DON conducted random audits to ensure residents were secured correctly. The facility planned to replace the wheelchair belt and shower belts. The investigation identified the facility corrected the noncompliance prior to the arrival of this investigation; and was in substantial compliance on 10/16/17.	F 323		